

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1604	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER MANCHESTER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 395 INTERSTATE DRIVE MANCHESTER, TN 37355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During the State Licensure Survey completed December 10 to December 13, 2012, no deficiencies were cited under 1200-8-6 Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

FR3Z11

TITLE

ADMINISTRATOR

(X6) DATE

12-27-12

If continuation sheet 1 of 1

JAN 02 2013